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9
10 **BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**
11

12
13 In the Matter of the Accusation Against:

Case No. 2010-62

14 **KYLE D. STUTTS**
111 Meadowpark Lane
15 Rockwall, Texas 75032

A C C U S A T I O N

16 **Registered Nurse License No. RN 670870**

17 Respondent.
18

19 Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

20 **PARTIES**

21 1. Complainant brings this Accusation solely in her official capacity as the Interim
22 Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer
23 Affairs.

24 **License History**

25 2. On or about December 19, 2005, the Board issued Registered Nurse License
26 Number 670870 ("license") to Kyle D. Stutts ("Respondent"). The license was in full force and
27 effect at all times relevant to the charges brought herein and will expire on December 30, 2009,
28 unless renewed.

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2 **STATUTORY PROVISIONS**

3 3. Section 2750 of the Business and Professions ("Code") provides, in pertinent part,
4 that the Board may discipline any licensee, including a licensee holding a temporary or an
5 inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of
6 the Nursing Practice Act.

7 4. Code section 2764, in pertinent part, that the expiration of a license shall not
8 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or
9 to render a decision imposing discipline on the license.

10 5. Code section 118, subdivision (b), provides that the suspension, expiration,
11 surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a
12 disciplinary action during the period within which the license may be renewed, restored, reissued
13 or reinstated.

14 6. Code section 2761 states, in pertinent part:

15 The board may take disciplinary action against a certified or
16 licensed nurse or deny an application for a certificate or license for any of
the following:

17 (a) Unprofessional conduct, which includes, but is not limited to,
18 the following:

19 (4) Denial of licensure, revocation, suspension, restriction, or any
20 other disciplinary action against a health care professional license or
21 certificate by another state or territory of the United States, by any other
government agency, or by another California health care professional
licensing board. A certified copy of the decision or judgment shall be
conclusive evidence of that action.

22 **COST RECOVERY**

23 7. Code section 125.3 provides, in pertinent part, that the Board may request the
24 administrative law judge to direct a licensee found to have committed a violation or violations of
25 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
26 enforcement of the case.

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1 **CAUSE FOR DISCIPLINE**

2 **(Out-of-State Discipline)**

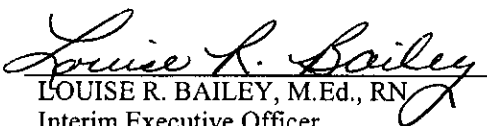
3 8. Respondent is subject to disciplinary action under Code section 2761, subddivision
4 (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Texas
5 Board of Nursing ("Texas Board"). In the case entitled, *In the Matter of Registered Nurse*
6 *License Number 726212 issued to Kyle D. Stutts*, pursuant to the Texas Board's Findings of Fact,
7 Conclusions of Law, and Final Agency Order, effective February 10, 2009, the Texas Board
8 suspended Respondent's Registered Nurse License No. 726212 for a period of two years with the
9 suspension stayed and placed Respondent on probation for two years with terms and conditions of
10 probation. The underlying circumstances of the discipline are that Respondent failed to clarify a
11 physician's order for Lidocaine which he administered to a patient which caused a seizure
12 followed by cardiac arrest. A copy of the Texas Board's Order is attached as **Exhibit A**, and is
13 incorporated herein.

14 **PRAYER**

15 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
16 and that following the hearing, the Board of Registered Nursing issue a decision:

- 17 1. Revoking or suspending Registered Nurse License Number RN 670870, issued to
18 Kyle D. Stutts;
- 19 2. Ordering Kyle D. Stutts to pay the Board the reasonable costs of the investigation and
20 enforcement of this case, pursuant to Code section 125.3; and,
- 21 3. Taking such other and further action as deemed necessary and proper.
- 22

23 DATED: 8/5/09


24 LOUISE R. BAILEY, M.Ed., RN
25 Interim Executive Officer
26 Board of Registered Nursing
27 Department of Consumer Affairs
28 State of California
Complainant

SA2009310728

EXHIBIT A
Texas Board of Nursing
ORDER

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse License Number 726212 § AGREED
issued to KYLE D. STUTTS § ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board, produced evidence indicating that KYLE D. STUTTS, hereinafter referred to as Respondent, Registered Nurse License Number 726212, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on October 7, 2008, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was represented by Nancy Roper Willson, Attorney at Law. In attendance were Denise Benbow, MSN, RN, CMSRN, Nurse Consultant, Executive Director's Designee; John F. Legris, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Erin Meneffe, Investigator; Christen Werley, Investigator; Amy Grissom, RN, Investigator; Jennifer Ellis, RN, Investigator; and Kim L. Williamson, RN, Investigator.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.
2. Respondent waived notice and hearing, and consented to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas.
4. Respondent received Certificate in Vocational Nursing in California. Respondent received an Associate Degree in Nursing from Excelsior College, Albany, New York, in May 2005. Respondent was licensed to practice vocational nursing in the State of California on October 19, 1995, was licensed to practice professional nursing in the State of California on

December 19, 2005, and was licensed to practice professional nursing in the State of Texas on March 23, 2006.

5. Respondent's professional employment history includes:

10/95 to 5/00	Unknown
6/00 to 6/03	Licensed Vocational Nurse (LVN) California Department of Corrections Sacramento, California
9/03 to 1/06	LVN & Registered Nurse (RN) Medstaff Riverside, California
2003 to Unknown	RN, Recruiter Medstaff Philadelphia, Pennsylvania
1/06 to 4/06	RN Riverside Community Hospital Riverside, California
4/06 to 8/06	RN Medical Center of McKinney McKinney, Texas
8/06 to 11/06	RN Campbell Health System Weatherford, Texas
11/06 to 3/07	RN Kaiser Permanente Harbor City, California
3/07 to 12/07	RN The Heart Hospital Baylor Plano Plano, Texas
1/08 to 10/08	RN, Agency Nurse Nightengale Nurses Assigned to:
1/08 to 4/08	Harris Methodist HEB Hospital Bedford, Texas
4/08 to 7/08	Riverside Community Hospital Riverside, California
8/08 to 10/08	Harris Methodist HEB Hospital Bedford, Texas

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Respondent's professional employment history continued:

10/08 to Present

RN, Emergency Department
Harris Methodist HEB Hospital
Bedford, Texas

6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as a RN with The Heart Hospital Baylor Plano, Plano, Texas, and had been in this position for nine (9) months.
7. On or about December 22, 2007, while employed as a RN with The Heart Hospital Baylor Plano, Plano, Texas, Respondent failed to clarify a physician's order for Lidocaine 1 gram to be administered intravenous push (IVP) to Emergency Department Patient Medical Record Number 5883, who had an Implantable-Cardioverter Defibrillator (ICD) which had fired twice. Lidocaine is a potent cardiac antiarrhythmia medication. Respondent administered an initial dose of Lidocaine 100mg IVP followed by a second dose of 600mg IVP. The usual dose of Lidocaine IVP is 50 mg to 100 mg not to exceed 300 mg in one (1) hour. After the 600mg dose was administered, the patient experienced a seizure followed by cardiac arrest and did not survive. Respondent's late documentation, submitted days later, included that he had questioned the physician about the order for Lidocaine 1 gram IVP, that he asked another nurse who had directed him to check with the physician, and that although he still had doubts about the dose, he administered the Lidocaine 600 mg IVP. Respondent's conduct may have contributed to the patient's demise.
8. On or about December 22, 2007, while employed as a RN with The Heart Hospital Baylor Plano, Plano, Texas, Respondent failed to accurately and timely document the administration of the total doses of Lidocaine IVP that he administered to the aforementioned Patient Medical Record Number 5883. Respondent did not document the administration of Lidocaine on the code sheet, and only documented the initial dose of Lidocaine 100 mg IVP in the nurses notes at 9:05 p.m. Respondent retrieved the discarded Lidocaine vials from the sharps container and filled them with water, then asked an assistant to dispose of the vials on another floor of the hospital. When the assistant refused and returned the vials, Respondent disposed of the vials in the emergency department. The vials were analyzed and evidence of dilution was found. Several days later, Respondent submitted late nurses notes which included the administration of Lidocaine 600mg IVP. The late documentation also included that Respondent had questioned the physician's order for Lidocaine 1 gram IVP and that he had doubts about the dose before he administered the medication. Respondent's conduct was deceptive.
9. In response to the incidents in Finding of Fact Number Seven (7), Respondent states that he questioned the physician, who told him again to administer Lidocaine 1 gram IVP and that he asked another nurses about the dose, who directed him to check with the physician. Respondent states that although he could not get clarity regarding his questions about the appropriateness of the Lidocaine dose, which he doubted, he proceeded to draw up and administer the 600mg of Lidocaine. Regarding the vials, Respondent states that he retrieved

the vials of Lidocaine from the sharps container because the physician wanted to see them, that he returned one immediately to the sharps container, and that he brought the other to the physician, telling her that was what she had ordered. Respondent then asked the assistant if she would dispose of the vial since she was going upstairs. The assistant was not comfortable with that, so Respondent took the vial back to dispose of himself.

10. On September 12, 2008, Respondent attended the course Nursing in Texas: A Regulatory Foundation for Safer Practice, which would have been a requirement of this Order.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§ 217.11(1)(A),(1)(B), (1)(C),(1)(D),(1)(M)&(1)(N) and 217.12(1)(A),(1)(B),(1)(C),(1)(E),(4)&(6)(H).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 726212, heretofore issued to KYLE D. STUTTS, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that Registered Nurse License Number 726212, previously issued to KYLE D. STUTTS, to practice nursing in Texas is hereby SUSPENDED for a period of two (2) years with the said suspension STAYED and Respondent is hereby placed on PROBATION for two (2) years with the following agreed terms of probation:

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate privilege, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this order, Respondent may not work outside the State of Texas pursuant to a

multistate licensure privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

(1) RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

(2) RESPONDENT SHALL deliver the wallet-sized license issued to KYLE D. STUTTS, to the office of the Texas Board of Nursing within ten (10) days of the date of this Order.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office

of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*
<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://www.learningext.com/products/generalce/critical/ctabout.asp>.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE A THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS PROBATIONARY PERIOD.

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(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the probation conditions on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the probation conditions on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(6) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) For the first year of employment as a Registered Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) For the remainder of the probationary period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to

be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) RESPONDENT SHALL NOT practice as a professional nurse in any critical care area of employment as a professional nurse for the duration of this ORDER **with the exception of Respondent's current employment in the Emergency Department with Harris Methodist HEB, Bedford, Texas.** Critical care areas include, but are not limited to, intensive care units, emergency rooms, operating rooms, telemetry units, recovery rooms, and labor and delivery units.

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) of employment as a nurse.

IT IS FURTHER AGREED and ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's license, the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

IT IS FURTHER AGREED that, upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license to practice nursing in the State of Texas.

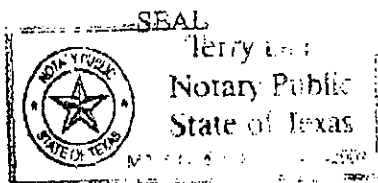
RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 8th day of JANUARY, 2008.

KYLE D. STUTTS, Respondent

Sworn to and subscribed before me this 8th day of JANUARY, 2008.



Notary Public in and for the State of TEXAS

Approved as to form and substance.

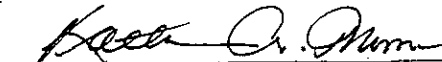
Nancy Roper Willson
Nancy Roper Willson, Attorney for Respondent

Signed this 8th day of January, 2008

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NOTARY

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 8th day of January, 2009, by KYLE D. STUTTS, Registered Nurse License Number 726212, and said Order is final.

Effective this 10th day of February, 2009.



Katherine A. Thomas, MN, RN
Executive Director on behalf
of said Board

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